INLET PHYSICAL MEDICINE

NEW PATIENT REGISTRATION

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Gender: _____ M _____F

Marital Status: _____

Email: _____

May we contact you by email: _____ Y _____ N

Social Security Num:

Do you have a primary care physician? ____ Y ____ N

Occupation: _____ Employer: _____

Employer Address: _____

Work Phone: _____

How did you hear about our practice? _____

Emergency Contact Name:

Relationship to you:

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you have health insurance? _____ Y _____ N

Policy Holder Name: _____ DOB: _____

Relationship to patient (if other than self): _____ Phone Number: _____

Name of Carrier: _____

Do you have secondary insurance? _____ Y _____N

Name of Carrier: _____

Is this visit due to an accident? _____ Y _____ N

If yes, what type: _____

Has it been reported? _____ Y _____ N

If yes, to whom? _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I authorize, request and assign my insurance company to pay directly to the physician/medical practice, insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: _____ DATE: _____

Inlet Physical Medicine Health History

What brings you in to see us today? _____
_____
_____

Please check if you have a history of any of the following conditions:

___ Arthritis
___ Gout
___ Anesthesia complications
___ Seasonal allergies
___ Sinus problems
___ Autoimmune diseases
___ Bleeding disorders
___ Cancer
___ Heart problems
___ Eye/vision problems
___ Diabetes
___ Bowel problems
___ Reflux/stomach ulcers
___ Female problems
___ Prostate problems
___ High blood pressure
___ High cholesterol
___ Seizures
___ Migraines
___ Orthopedic/Spine problems
___ Depression
___ Anxiety
___ Asthma
___ COPD/emphysema
___ Recent infections
___ Kidney problems
___ Skin problems
___ Insomnia
___ Sleep apnea
___ Stroke/mini-stroke
___ Thyroid problems
___ Circulation problems
___ Substance Abuse
___ Other _____
_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____
_____
_____
_____

Are you currently under the care of any specialists? If yes, who and for what reason: _____
_____

Do you exercise regularly? If yes, what do you do: _____

Do you drink caffeine? If yes, how many cups a day? _____

Do you use tobacco products? If yes, what type and amount: _____

Do you drink alcohol? (circle one) Never Rare Social Couple times a week Daily

Do you have a Living Will or Advanced Directives? Yes No

Do you have a medical Power of Attorney? Yes No

Inlet Physical Medicine Health History

Does anyone in your family have any of the following conditions? Please indicate which family member.

1. Heart Disease: _____
2. Cancer: _____
3. Diabetes: _____
4. High blood pressure: _____
5. High cholesterol: _____
6. Stroke: _____

Have you had the following tests?

1. Bone Density Test	Yes	No	If yes, when_____
2. Cardiac Stress Test	Yes	No	If yes, when_____
3. Colonoscopy	Yes	No	If yes, when_____
4. Mammogram	Yes	No	If yes, when_____
5. Pap Test	Yes	No	If yes, when_____
6. Prostate Exam/PSA	Yes	No	If yes, when_____
7. Echocardiogram (heart ultrasound)	Yes	No	If yes, when_____
8. Skin Exam	Yes	No	If yes, when_____
9. Eye exam in the last 2 years	Yes	No	If yes, when_____
10. Dental exam in the last year	Yes	No	If yes, when_____

Have you had any of the following immunizations?

Influenza Hepatitis A or B HPV Meningitis Tetanus Pertussis Pneumovax Shingles

Please list any allergies you have: _____
_____
_____

Please list any prescription medications you are taking: _____
_____
_____
_____

Please list any supplements you are taking (vitamins/herbs/minerals): _____
_____
_____

Which pharmacy to you use (local & mail order): _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ DATE:_____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____DOB:_____

I acknowledge that I have reviewed the Notice of Privacy Practices of Inlet Physical Medicine, LLC. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is:_____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Inlet Physical Medicine, LLC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Office Manager, James Walker, about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date

Inlet Physical Medicine

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____ If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

My Emergency Contact is: _____

They can be reached at: _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Inlet Physical Medicine
804 B Inlet Sq. Drive
Murrells Inlet, SC 29576
843-652-5678

Wellness Program
Individual Consent, Release, Waiver of Liability and Indemnity Agreement

I understand and agree that the exercise opportunities offered through the facility of Inlet Physical Medicine, LLC (hereafter I.P.M.) allows a person to engage in various exercises and/or physical activities potentially beneficial to one's health and well being.

However, I recognize and understand that there are inherent risks of various physical and mental conditions, illness, and/or injuries associated with: (a) engaging in any exercise or physical activity, (b) the use of equipment at I.P.M. And/or (c) the use of any and all I.P.M. facilities. I recognize and understand such risks include any and all types of physical and/or mental injuries.

I further recognize and understand that any and all such risks are compounded, in that the exercise and/or physical activity opportunities of I.P.M. are unsupervised including, but not limited to, the use of all types of exercise equipment.

I hereby agree and consent to voluntarily engage in any and all exercise and physical activity opportunities, supervised or unsupervised, at I.P.M. I also agree and consent to voluntarily use the I.P.M. exercise equipment and to voluntarily use the I.P.M. facilities at my own risk and with full knowledge and appreciation of any and all dangers and risks inherent therein.

I hereby assume full responsibility for any and all risks of any and all bodily injury, illness, and/or property damage or loss suffered by me.

I hereby release, waive, and forever discharge and/or covenant not to sue I.P.M., I.P.M.'s owner, director, officer, agents, servants, and/or it's employees for any and all loss, liability, damage or cost of any type which I may incur as a result of or related to any injury, illness, condition, and/or injury to my person or property as a result of engaging in any exercise and activity opportunities at I.P.M. and any use of I.P.M. equipment and/or the use of any of the I.P.M. facilities.

I hereby acknowledge that I have read the preceding prior to agreeing, and understand that I am executing a consent, release, waiver of liability, and indemnity agreement document.

_____ _____

Print Name/Signature Date

_____ _____

Witness Signature Date

Inlet Physical Medicine

Office Financial Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies providing the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and/or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process an claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately..
14. If this office gives you any professional or accounting discounting for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____

Patient's Signature or Responsible Party Date

804 Unit B Inlet Square Drive | Murrells Inlet, SC 29576
Office: 843-652-5678 | Fax: 843-652-5679 | www.InletPhysicalMedicine.com

A. Notifier: Inlet Physical Medicine, LLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **(D)** listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) listed below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Maintenance Therapy	**Not Covered under Medicare Program**	**$35.00/visit**
Therapeutic Therapy	**Not Covered under Medicare Program**	**$35.00/visit**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **(D)**listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the (D) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **(D)** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

A. Notifier: Inlet Physical Medicine, LLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for (D) listed below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) listed below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Durable Medical Equipment	Not Allowed or Not Considered Medically Necessary	$10 to $1,000

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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